



Intellectual and/or Developmental Disabilities (IDD)
Application for Rule 185 Case Management

Please submit information:

Mail: Washington County Community Services, ATTN: IDD Intake
P.O. Box 30, 14949 62nd Street N., Stillwater, MN 55082

Fax: "ATTN: IDD Intake" at 651-430-6527

Email: CSAAD-IDD-Eligibility@washingtoncountymn.gov; include "IDD Application Information" on the subject line

Phone: 651-430-6422

**Please complete this application from the view of the person who is applying for services.*

Full Name: _____ Preferred Name: _____

Date of Birth: _____ Social Security #: _____ MA/TEFRA/PMI #: _____

Address: _____

Phone: Cell: _____ Home: _____ Work: _____

Email: _____

Do you have private health insurance? Yes No

Ethnicity or Race (optional): _____ Gender Identity (optional): _____

Parent's Name: _____ Phone: _____ Email: _____

Address: _____

Parent's Name: _____ Phone: _____ Email: _____

Address: _____

Guardian (if applicable): _____ Phone: _____

Address: _____ Email: _____

Legal Status/Type: Minor Child Own Private Conservator Private Guardian State Ward

Do you need an interpreter? Yes No If so, what language? _____

Do you have other people in your immediate family? _____

Do you have anyone else currently supporting you? Yes No

(Please include all family, friends, neighbors, or agencies supporting you including programs such as Personal Care Assistance (PCA), case managers, or other service providers.)

Are you currently enrolled in school? Yes No

(If so, what grade are you? Do you have a primary person at the school that helps support you? What is their contact information?)

Diagnostic Information

Date of last diagnostic evaluation: _____

Name/credentials of the person that completed this testing: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Full Scale IQ: _____

Date of other diagnostic or testing: _____

Name/credentials of the person that completed this testing: _____

Primary Diagnosis: _____

Secondary Diagnosis: _____

Full Scale IQ: _____

Are there any other health care providers you wish to share with us? Yes No

Please list them here if you would like to (it is not required):

Birth & Developmental Story

Describe pregnancy and delivery information that did or may have affected development (such as premature delivery, complications, etc.):

When did you notice challenges with developmental milestones? Can you describe what this looked like (i.e. ages first sat up, crawled, walked, talked, etc.)?

Describe social strengths and areas that may be more challenging (such as making friends, following a routine, doing fun things in and out of the house, being able to be home alone, etc.):

Please share any additional information about strengths or areas where support is needed (such as information not captured in the MnCHOICES assessment or if you did not have a MnCHOICES assessment):

Home Information

Describe the places you have lived or stayed (such as with parents, other family, or in a group home or hospital):

Additional Support Information

Is there anything specific you are looking for help with? Are there specific programs or services you are interested in exploring? (Please note: If you are eligible for IDD case management, there are program and service eligibility criteria that we are required to follow. Please understand that if you are asking for a specific program or waiver on this application, specific eligibility criteria will need to be met, and an approval process will need to be followed.)

Completed by _____

_____ Date